

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Childhood Immunization Certification
Temporary Assistance for Needy Families (TANF) & Child Care Subsidy

Parents: Children need shots at about 2, 4, 6, 12-15 months of age, before kindergarten, and at 11-12 years of age. You must show that your child has the shots he/she needs or you could lose some of your TANF benefits/child day care subsidy. To avoid losing benefits/subsidy:

- Take this form and shot records with you each time you take your child to the doctor or health department.
- Have your doctor or nurse sign below each time your child gets shots.
- Take this form with you each time you see your eligibility worker or child day care worker.

CHILD'S NAME	SSN	DOB	CASE NO.
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PARENT/GUARDIAN NAME

Doctor/Providers: Children who receive TANF benefits and who are not in school or in licensed daycare are required to have certification that they are up-to-date for all recommended immunizations, that they are being brought up-to-date or that they are medically exempt. All children who receive a child day care subsidy are required to be age-appropriately immunized. Failure to document immunizations may result in the child losing a portion of his/her TANF benefits or child day care subsidy.

Please complete one visit section of this form each time you screen immunization records for or immunize the child named above.

1. FIRST VISIT

Please check the correct box.

- ☒ ☐ ☐ ☐ The above-named child is age appropriately immunized, as of the date of this visit.
- ☐ The child has received at least one dose of each of the vaccines to make him/her appropriately immunized, as of the date of this visit.
- ☐ The child is medically exempt from these vaccines, as of the date of this visit.
- This contraindication is permanent ☐.
- This contraindication is temporary ☐.
- Please name the vaccines: _____

Medical Provider Name: _____

Address: _____

Phone: _____

Signature/Stamp: _____

Visit Date: _____

Month/Day/Year next Immunization Due: _____

2. SECOND VISIT

Please check the correct box.

- ☒ ☐ ☐ ☐ The above-named child is age appropriately immunized, as of the date of this visit.
- ☐ The child has received at least one dose of each of the vaccines to make him/her appropriately immunized, as of the date of this visit.
- ☐ The child is medically exempt from these vaccines, as of the date of this visit.
- This contraindication is permanent ☐.
- This contraindication is temporary ☐.
- Please name the vaccines: _____

Medical Provider Name: _____

Address: _____

Phone: _____

Signature/Stamp: _____

Visit Date: _____

Month/Day/Year next Immunization Due: _____

Childhood Immunization Certification

CHILD'S NAME	SSN	DOB	CASE NO.
3. THIRD VISIT			
Please check the correct box. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> The above-named child is age appropriately immunized, as of the date of this visit. <input type="checkbox"/> The child has received at least one dose of each of the vaccines to make him/her appropriately immunized, as of the date of this visit. <input type="checkbox"/> The child is medically exempt from these vaccines, as of the date of this visit. This contraindication is permanent <input type="checkbox"/> . This contraindication is temporary <input type="checkbox"/> .: Please name the vaccines:		Medical Provider Name: Address: Phone: Signature/Stamp: Visit Date:	
Month/Day/Year next Immunization Due: _____			
4. FOURTH VISIT			
Please check the correct box. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> The above-named child is age appropriately immunized, as of the date of this visit. <input type="checkbox"/> The child has received at least one dose of each of the vaccines to make him/her appropriately immunized, as of the date of this visit. <input type="checkbox"/> The child is medically exempt from these vaccines, as of the date of this visit. This contraindication is permanent <input type="checkbox"/> . This contraindication is temporary <input type="checkbox"/> .: Please name the vaccines:		Medical Provider Name: Address: Phone: Signature/Stamp: Visit Date:	
Month/Day/Year next Immunization Due: _____			
5. FIFTH VISIT			
Please check the correct box. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> The above-named child is age appropriately immunized, as of the date of this visit. <input type="checkbox"/> The child has received at least one dose of each of the vaccines to make him/her appropriately immunized, as of the date of this visit. <input type="checkbox"/> The child is medically exempt from these vaccines, as of the date of this visit. This contraindication is permanent <input type="checkbox"/> . This contraindication is temporary <input type="checkbox"/> .: Please name the vaccines:		Medical Provider Name: Address: Phone: Signature/Stamp: Visit Date:	
Month/Day/Year next Immunization Due: _____			
6. SIXTH VISIT			
Please check the correct box. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> The above-named child is age appropriately immunized, as of the date of this visit. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> The child has received at least one dose of each of the vaccines to make him/her appropriately immunized, as of the date of this visit. <input type="checkbox"/> The child is medically exempt from these vaccines, as of the date of this visit. This contraindication is permanent <input type="checkbox"/> . This contraindication is temporary <input type="checkbox"/> .: Please name the vaccines:		Medical Provider Name: Address: Phone: Signature/Stamp: Visit Date:	
Month/Day/Year next Immunization Due: _____			

For immunization information, please call your local Health Department or the Virginia Department of Health, Bureau of Immunization at 1-800-568-1929.

